Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS BACK INSTITUTE
PO BOX 262409
PLANO TX 75026-2409

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box

Box Number 45

MFDR Tracking Number

M4-10-3453-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have billed and appealed a claim on the above patient with SORM. They continued to deny dos stating authorization was not done. According to ODG procedure code 97799 should not exceed 160 hours or the equivalent in part-day sessions. We billed 159 hours over 26 days. SORM states the authorization is good for 20 days. This is not how we are interpreting the ODG. I have attached a copy of the ODG, pre-authorizations and emails with SORM for your review."

Amount in Dispute: $2250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The preauthorization 1024446 F 1 that was certified on 5/1/09 gave the requestor initially 10 sessions of Chronic Pain Management that were performed on 5/11/09, 5/12/09, 5/13/09, 5/14/09, 5/18/09, 5/19/09, 5/20/09, 5/21/09, 5/22/09, and 5/27/09. Further review found that preauthorization 1026925 F 1 certified on 6/1/09 gave an additional 10 sessions of Chronic Pain management that were performed on 6/1/09, 6/2/09, 6/3/09, 6/4/09, 6/5/09, 6/8/09, 6/9/09, 6/10/09, 6/11/09, and was completed on 6/12/09. The Office determined that dates of service 5/28/09, 5/29/09, 6/15/09 and 6/16/09 fell outside the number of sessions that were preauthorized by Forte." "The Chronic Pain Management ODG criteria states: 12) Total treatment duration should generally not exceed 20 full-day (160) sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comobidities)…" "Further review of the requestor's request for preauthorization, the Office found that the requestor had failed to submit documentation to indicate that the sessions would need to be part-day sessions, therefore Forte authorized on 1024446 F1 the requested 10 sessions (80 hours) as indicated by the ODG after a peer to peer with the requesting physician in which the reviewing physician documents on the peer to peer form "*O.K. for 10 days CPMP.* In the documented peer to peer discussion, the requesting physician makes no mention of the injured worker being **unable** to attend 10 full-days (80 hours) **nor** submits documented medical evidence of the injured workers inability to attend the program on a full-day (8 hour) basis as intended by the ODG-Chronic Pain Management Criteria."

Response Submitted by: SORM, P.O. Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 27, 2009 May 28, 2009	Chronic Pain Management – CPT code 97799-CP-CA (7 hours)	$875.00/day X 2 = $1750.00	$1750.00
May 29, 2009	Chronic Pain Management – CPT code 97799-CP-CA (1 hours)	$125.00	$125.00
June 16, 2009	Chronic Pain Management – CPT code 97799-CP-CA (3 hours)	$375.00	$375.00
TOTAL		$2250.00	$2250.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective *March 1, 2008, 33 TexReg 626*, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, effective May 2, 2006 requires preauthorization for a chronic pain management program.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits June 15, 2009
   - 152-Payment adjusted/undocumented length svc.
   - 16-Not all info needed for adjudication was supplied.

   Explanation of benefits July 27, 2009
   - 152-Payment adjusted/undocumented length svc.
   - 16-Not all info needed for adjudication was supplied.

   Explanation of benefits July 31, 2009
   - 152-Payment adjusted/undocumented length svc.
   - 16-Not all info needed for adjudication was supplied.
   - W4-No additional payment allowed after review.

   Explanation of benefits August 19, 2009
   - 152-Payment adjusted/undocumented length svc.
   - 16-Not all info needed for adjudication was supplied.
   - W4-No additional payment allowed after review.

   Explanation of benefits October 26, 2009
   - 193-Original payment decision is being maintained. This claim was processed properly the first time.
   - PRE AUTH 1024446F1 AUTHORIZED 10 SESSIONS OF CPM WHICH WERE COMPLETED WITH THE FOLLOWING DOS 05/11, 12, 13, 14, 18, 19, 20, 21, 22, 26.
   - PRE AUTH 102692F1 AUTHORIZED 10 SESSIONS OF CPM WHICH WERE COMPLETED WITH 06/01, 2, 3, 4, 5, 9, 10, 11, 12, 15.

Issues

1. Did the requestor obtain preauthorization for the disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.600(p)(10) requires preauthorization for "chronic pain management/interdisciplinary pain rehabilitation."

   Initial Request/Approval:

   The Respondent submitted a report dated April 30, 2009 that indicates that "REQUEST: 10 SESSIONS OF CPMP".

   The Respondent's facsimile coversheet dated April 30, 2009 states "SERVICES REQUESTED: Outpatient CPMP times 10 sessions as related to the low back". "Your authorization number is 1024446F1." "We will be faxing you a written notification letter within one business day."

   The May 1, 2009 preauthorization report states "After peer to peer review, it is the opinion of the reviewing physician that Recommend AUTHORIZATION of outpatient chronic pain management program (CPMP) times ten (10) sessions as related to the low back…Approve 10 day trial of CPMP."

   28 Texas Administrative Code §134.600 (n) states "The carrier shall not condition an approval or change any elements of the request as listed in subsection (f) of this section, unless the condition or change is mutually agreed to by the health care provider and carrier and is documented." The Division finds that the respondent supported position that the preauthorization request was for 10 sessions of chronic pain management program. The respondent's authorization letter changed from 10 sessions as stated on the request and facsimile coversheet, to "10 days" on the report. The respondent did not submit documentation to support that this change was mutually agreed upon; therefore, the Division finds that the preauthorization was for the ten sessions of chronic pain management program.

   Second Request/Approval:

   The respondent submitted a report dated June 1, 2009 that states: SORM Request: CPMP x 80 add'l hours 58/F/"

   The June 2, 2009 preauthorization report states "After peer to peer review, it is the opinion of the reviewing physician that Recommend AUTHORIZATION of outpatient chronic pain management program (CPMP) five (5) times a week for two (2) sessions as related to the low back…Claimant has now completed 80 hours of CPMP. Request is consistent with ODG in that functional and objective progress is noted in psychological and physical function."

   The Division finds that the requestor has further supported position that the initial authorization was for ten sessions or 80 hours of CPMP as stated in the second report. Therefore, the Division concludes that the requestor obtained preauthorization for 20 sessions or 160 hours of chronic pain management program.

2. The requestor submitted email correspondence between Kathy Britt from the Texas Back Institute to Janine Lychman with SORM that finds the following: December 3, 2009: "I have reviewed the authorization for the pain management. Authorization # 1024446F1 states this is for 10 sessions. The paid dos 5/11, 12, 13, 14, 18, 19, 20, 21, 22, and 26th was billed for a total of 69 hours. DOS 6/1; 2; 3, 4, 5, 9, 10, 11, 12, and 15th was billed for a total of 70 hours. Therefore, the additional units left should cover the remainder dos. According to ODG, the total treatment should not exceed 20 full day (160 hours) session (or the equivalent in part-day sessions)."

   A review of the billing finds that the requestor billed for 79 hours from May 11, 2009 through May 29, 2009; and billed 80 hours from June 1, 2009 through June 16, 2009 for a total of 159 hours or 20 sessions. The respondent paid for 64 hours from May 11, 2009 through May 29, 2009; and paid 70 hours and 21 minutes from June 1, 2009 through June 16, 2009. The requestor has supported position that they did not exceed the preauthorized services; therefore, additional reimbursement is due.

3. 28 Texas Administrative Code §134.204(h)(1)(A) states "(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR."

   28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

The Division finds that the requestor's documentation supports the billed CPT code 97799-CP-CA for seven (7) hours on May 27, 2009 and May 28, 2009; one (1) hour on May 29, 2009; and three (3) hours on June 16, 2009. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(A) and (5)(A) and (B), the MAR for a CARF accredited program is $125.00 x eighteen (18) hours = $2250.00. The carrier paid $0.00. Therefore, the difference between the MAR and amount paid is $2250.00. This amount is recommended for reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor. For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2250.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2250.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		4/9/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.